

**OUT-OF-HOME CARE
SUPPORT PLAN EVALUATION / REVISION**

Name – Foster Parent 1 (Last, First, MI)	Name – Foster Parent 2 (Last, First, MI)	Provider ID
Name – Licensing Specialist		Date (mm/dd/yyyy)

EVALUATION OF PREVIOUS SUPPORT PLAN

Describe the results of the previous support plan.

Explain how the issues identified were either achieved or not achieved.

How did the outcomes achieved strengthen the quality of foster parenting?

CURRENT PREFERENCES AND STRENGTHS

Describe any placement preferences and / or considerations indicated by the foster parent(s), including age, gender, race, special needs, contact with birth families, etc.

Describe any strengths observed and / or indicated by the foster parent(s), including skills, education, resources, support network, functional strengths, etc.

AREAS NEEDING SUPPORT AND / OR STRENGTHENING

Describe any new or unresolved concerns / needs requiring support or strengthening. (Include HFS 56 violations, identified concerns, and training goals. As appropriate, include information from collateral sources such as service providers, ongoing caseworkers, adoption workers, or CASA volunteers.)

If the new child is placed in the home, describe what new types of support or services are provided to the foster parent(s) to care for the child's specific needs.

With the addition of a new child, what new resources or support system are available to the foster parent(s) during periods of high stress or crisis that will allow the foster parent(s) to reduce this stress? What steps will the foster parent(s) take that are planned in advance when they are faced with a high stress or crisis situation?

SERVICES TO SUPPORT FOSTER PARENT(S)

Service	Responsible Party (Agency, Ed. Program, Natural Supports, OHC Consultant, Foster Parent, etc.)	Frequency (One-time, Weekly, etc.)	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
1.				
2.				
3.				
4.				
5.				

OUTCOME MEASUREMENTS

What is the desired outcome of support? Relate measurable outcome to needs or concerns requiring support and / or strengthening.

Describe the indicators and / or measure(s) of successful use of support services to increase skills and abilities.

SIGNATURES

SIGNATURE – Foster Parent

Date Signed

SIGNATURE – Foster Parent

Date Signed

SIGNATURE – Licensing Specialist

Date Signed

SIGNATURE – Licensing Supervisor

Date Signed